

CONFIDENTIAL

Reservoir High School Music

All Medications Form



SCHOOL YEAR 20

to 20

USE ONE FORM FOR EACH STUDENT

USE THIS FORM FOR ALL MEDICATIONS, OVER-THE-COUNTER AND PRESCRIPTION, THAT MIGHT BE ADMINISTERED DURING THE TRIP. THIS FORM MUST BE SIGNED BY A PHYSICIAN.

LAST Name:

First Name:

Birth Date:

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Use MM/DD/YYYY format for Birth Date.

Physician Name:

Address:

Office Phone:

State/Province:

Zip:

-- ENTER ONE MEDICATION ON EACH LINE --

Medication	Prescription or Over-the Cntr		Dose / Amount	When					Indication(s)
	<input type="checkbox"/> Rx	<input type="checkbox"/> OTC		<input type="checkbox"/> Brk	<input type="checkbox"/> Lun	<input type="checkbox"/> Din	<input type="checkbox"/> Bed	<input type="checkbox"/> As Need	
	<input type="checkbox"/> Rx	<input type="checkbox"/> OTC		<input type="checkbox"/> Brk	<input type="checkbox"/> Lun	<input type="checkbox"/> Din	<input type="checkbox"/> Bed	<input type="checkbox"/> As Need	
	<input type="checkbox"/> Rx	<input type="checkbox"/> OTC		<input type="checkbox"/> Brk	<input type="checkbox"/> Lun	<input type="checkbox"/> Din	<input type="checkbox"/> Bed	<input type="checkbox"/> As Need	
	<input type="checkbox"/> Rx	<input type="checkbox"/> OTC		<input type="checkbox"/> Brk	<input type="checkbox"/> Lun	<input type="checkbox"/> Din	<input type="checkbox"/> Bed	<input type="checkbox"/> As Need	
	<input type="checkbox"/> Rx	<input type="checkbox"/> OTC		<input type="checkbox"/> Brk	<input type="checkbox"/> Lun	<input type="checkbox"/> Din	<input type="checkbox"/> Bed	<input type="checkbox"/> As Need	
	<input type="checkbox"/> Rx	<input type="checkbox"/> OTC		<input type="checkbox"/> Brk	<input type="checkbox"/> Lun	<input type="checkbox"/> Din	<input type="checkbox"/> Bed	<input type="checkbox"/> As Need	
	<input type="checkbox"/> Rx	<input type="checkbox"/> OTC		<input type="checkbox"/> Brk	<input type="checkbox"/> Lun	<input type="checkbox"/> Din	<input type="checkbox"/> Bed	<input type="checkbox"/> As Need	
	<input type="checkbox"/> Rx	<input type="checkbox"/> OTC		<input type="checkbox"/> Brk	<input type="checkbox"/> Lun	<input type="checkbox"/> Din	<input type="checkbox"/> Bed	<input type="checkbox"/> As Need	

Medication: enter name from prescription or manufacturer's label. Check off whether prescription or over-the-counter.

Dose: Should be in units such as "100 mg" or "30 ml" rather than "Take one tablet".

When: Check each time the medication is to be given: Breakfast - Lunch - Dinner - Bedtime. ONE OF THESE SHOULD BE CHECKED. These WILL be given as noted. Indicate if medication is only "As Needed".

Indications: Enter any specific conditions to give the medication.

PHYSICIAN SIGNATURE: _____ DATE: ____/____/20____

THIS FORM IS INVALID WITHOUT SIGNATURE OF THE PHYSICIAN NAMED ABOVE.

PARENT/GUARDIAN SIGNATURE: _____ DATE: ____/____/20____

IF THIS FORM IS COMPLETED BY HANDWRITING, PLEASE PRINT ALL ENTRIES.

MEDICATIONS MUST BE IN EITHER A PHARMACY PRESCRIPTION BOTTLE OR A MANUFACTURER'S CONTAINER. ALL BOTTLES OR CONTAINERS MUST BE LABELED WITH THE STUDENT'S NAME.